



VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER

Department of Veterans Affairs

Department of Defense

Pocket Card

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.

These guidelines are not intended to represent TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil or by contacting your regional TRICARE Managed Care Support Contractor.

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I. Summary of Recommendations

Recommendations were made using a systematic approach considering multiple domains: the confidence in the quality of the evidence, balance of desirable and undesirable outcomes, patient or provider values and preferences, and other implications, as appropriate (e.g., resource use, equity, acceptability).

General Clinical Management

We recommend:

- Engaging patients in shared decision making (SDM), which includes educating patients about effective treatment options.

We suggest:

- Collaborative care interventions that facilitate active engagement in evidence-based treatments.

Diagnosis and Assessment of PTSD

We recommend:

- An appropriate diagnostic evaluation that includes determination of DSM criteria, acute risk of harm to self or others, functional status, medical history, past treatment history, and relevant family history. A structured diagnostic interview may be considered. (For patients with suspected PTSD)

We suggest:

- Periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) or the PTSD Checklist (PCL).
- Using a quantitative self-report measure of PTSD severity, such as the PTSD Checklist (PCL-5), in the initial treatment planning and to monitor treatment progress.

Treatment of PTSD

See [Table 1](#) and [Table 2](#) below for a summary of the pharmacotherapy recommendations

We recommend:

- Individual, manualized trauma-focused psychotherapy over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD.
- Pharmacotherapy or individual non-trauma-focused psychotherapy – there is insufficient evidence to recommend one over the other. (When individual trauma-focused psychotherapy is not readily available or not preferred)
- Individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.
- Using trauma-focused psychotherapies that have demonstrated efficacy using secure video conferencing (VTC) modality when PTSD treatment is delivered via VTC.

We suggest:

- The use of the following individual, manualized non-trauma-focused therapies: Stress Inoculation Training (SIT), Present-Centered Therapy (PCT), and Interpersonal Psychotherapy (IPT).
- Manualized group therapy over no treatment. There is insufficient evidence to recommend using one type of group therapy over any other.
- Internet-based cognitive behavioral therapy (iCBT) with feedback provided by a qualified facilitator as an alternative to no treatment.

There is insufficient evidence to recommend for or against:

- Psychotherapies that are not specified in other recommendations, such as Dialectical Behavior Therapy (DBT), Skills Training in Affect and Interpersonal Regulation (STAIR), Acceptance and Commitment Therapy (ACT), Seeking Safety, and supportive counseling.
- Individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol.
- Trauma-focused or non-trauma-focused couples therapy for the primary treatment of PTSD.
- Augmentation with pharmacotherapy in partial- or non-responders to psychotherapy.

- Augmentation with psychotherapy in partial- or non-responders to pharmacotherapy.
- Starting patients with PTSD on combination pharmacotherapy and psychotherapy.
- Use of the following somatic therapies: repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), hyperbaric oxygen therapy (HBOT), stellate ganglion block (SGB), or vagal nerve stimulation (VNS).

Treatment of PTSD with Co-occurring Conditions

We recommend:

- The presence of co-occurring disorder(s) not prevent patients from receiving other VA/DoD guideline-recommended treatments for PTSD.
- VA/DoD guideline-recommended treatments for PTSD in the presence of co-occurring substance use disorder.
- Independent assessment of co-occurring sleep disturbances in patients with PTSD, particularly when sleep problems pre-date PTSD onset or remain following successful completion of a course of treatment.
- Cognitive Behavioral Therapy for Insomnia (CBT-I) for insomnia in patients with PTSD unless an underlying medical or environmental etiology is identified or severe sleep deprivation warrants the immediate use of medication to prevent harm.

Table 1. Medication Augmentation and Combination* Pharmacotherapy for the Treatment of PTSD by Recommendation and Strength of Evidence

Quality of Evidence [‡]	Recommend For	Suggest For	Suggest Against	Recommend Against	No Recommendation For or Against
Moderate			Prazosin (excluding the treatment of PTSD associated nightmares)	Risperidone	Prazosin for the treatment of PTSD associated nightmares
Low			Topiramate	Divalproex Olanzapine	Hydrocortisone
Very Low			Baclofen Pregabalin D-cycloserine [†]		Mirtazapine and Sertraline [^]
No data [‡]				Other atypical antipsychotics	Any drug not listed

*Combination means treatments are started simultaneously; augmentation means one treatment is started after another treatment (all treatments are augmentation unless otherwise noted)

±The Work Group determined there was no high quality evidence regarding medication augmentation and combination therapy

†Outside of a research setting

[^]Combination treatment

‡No data were captured in the evidence review for this CPG and were not considered in development of this table

Table 2. Medication Monotherapy for the Treatment of PTSD by Recommendation and Strength of Evidence

Quality of Evidence *	Recommend For	Suggest For	Suggest Against	Recommend Against	No Recommendation For or Against
Moderate	Sertraline^ Paroxetine^ Fluoxetine Venlafaxine		Prazosin (excluding the treatment of PTSD associated nightmares)		Prazosin for the treatment of PTSD associated nightmares
Low		Nefazodone ‡	Quetiapine Olanzapine Citalopram Amitriptyline	Divalproex Tiagabine Guanfacine	Eszopiclone
Very Low		Imipramine Phenelzine‡	Lamotrigine Topiramate	Risperidone Benzodiazepines D-cycloserine Hydrocortisone Ketamine	Bupropion Desipramine D-serine Escitalopram Mirtazapine
No Data†					<u>Antidepressants</u> Doxepin Duloxetine‡ Desvenlafaxine Fluvoxamine‡ Levomilnacipran Nortriptyline Trazodone Vilazodone Vortioxetine <u>Anxiolytic/Hypnotics</u> Buspirone‡ Cyproheptadine Hydroxyzine Zaleplon Zolpidem

*The Work Group determined there was no high quality evidence regarding medication monotherapy

^FDA approved for PTSD

‡Serious potential toxicity, should be managed carefully

†No data were captured in the evidence review for the CPG and were not considered in development of this table

‡Studies of these drugs did not meet the inclusion criteria for the systematic evidence review due to poor quality

Table 3. Pharmacotherapy Dosing Table

Therapeutic Category	Initial Dose	Dose Range	Clinical Considerations: Comorbidities and Safety
Antidepressants Monotherapy <ul style="list-style-type: none"> ■ Fluoxetine* ■ Paroxetine* ■ Sertraline* ■ Venlafaxine* 	10-20 mg daily 10-20 mg daily 25-60 mg daily IR: 25 mg 2 or 3 times a day XR: 37.5 mg once daily	20-80 mg daily 20-50 mg daily 50-200 mg daily 75-375 mg in 2-3 divided doses 75-225 mg once daily	<ul style="list-style-type: none"> ■ Avoid abrupt discontinuation; withdrawal symptoms with sudden discontinuation of SSRIs and SNRIs, paroxetine and venlafaxine in particular ■ Paroxetine and sertraline have FDA label indications for treating PTSD ■ Common adverse effects of the SSRIs and SNRIs include nausea, headache, diarrhea, anxiety, nervousness, sexual dysfunction, agitation, dizziness, hyponatremia or SIADH, and serotonin syndrome ■ Venlafaxine can elevate blood pressure; caution advised with patients with hypertension ■ Nefazodone is associated with life-threatening hepatic failure; monitor for signs and symptoms including LFTs; avoid if active liver disease; do not re-challenge ■ Nefazodone is subject to many drug interactions, particularly those involving CYP3A4 and glycoprotein ■ Avoid TCAs within three months of an acute MI ■ TCAs are relatively contraindicated in patients with coronary artery disease or prostatic enlargement ■ TCAs side effects include dry mouth, dry eyes, constipation, orthostatic hypotension, tachycardia, ventricular arrhythmias, weight gain, and drowsiness Photosensitivity may occur ■ Phenzelzine considerations include drug-drug and drug-food interactions, risk of hypertensive crisis, hypotension, and anticholinergic effects
<ul style="list-style-type: none"> ■ Nefazodone± 	25–100 mg 2 times daily	150-600 mg in 2 divided doses	
<ul style="list-style-type: none"> ■ Imipramine± 	25-75 mg daily	100-300 mg in 1 or 2 divided doses	
<ul style="list-style-type: none"> ■ Phenzelzine± 	15 mg 3 times daily	15 mg daily; 90 mg in divided doses	

Abbreviations: FDA: Food and Drug Administration; IR: immediate release; LFT: liver function tests; mg: milligram; MI: myocardial infarction; PTSD: posttraumatic stress disorder; SIADH: syndrome of inappropriate anti-diuretic hormone; SIT: Stress Inoculation Training; SNRI: serotonin–norepinephrine reuptake inhibitors; SSRI: serotonin reuptake inhibitors; TCA: tricyclic antidepressants; XR: extended release

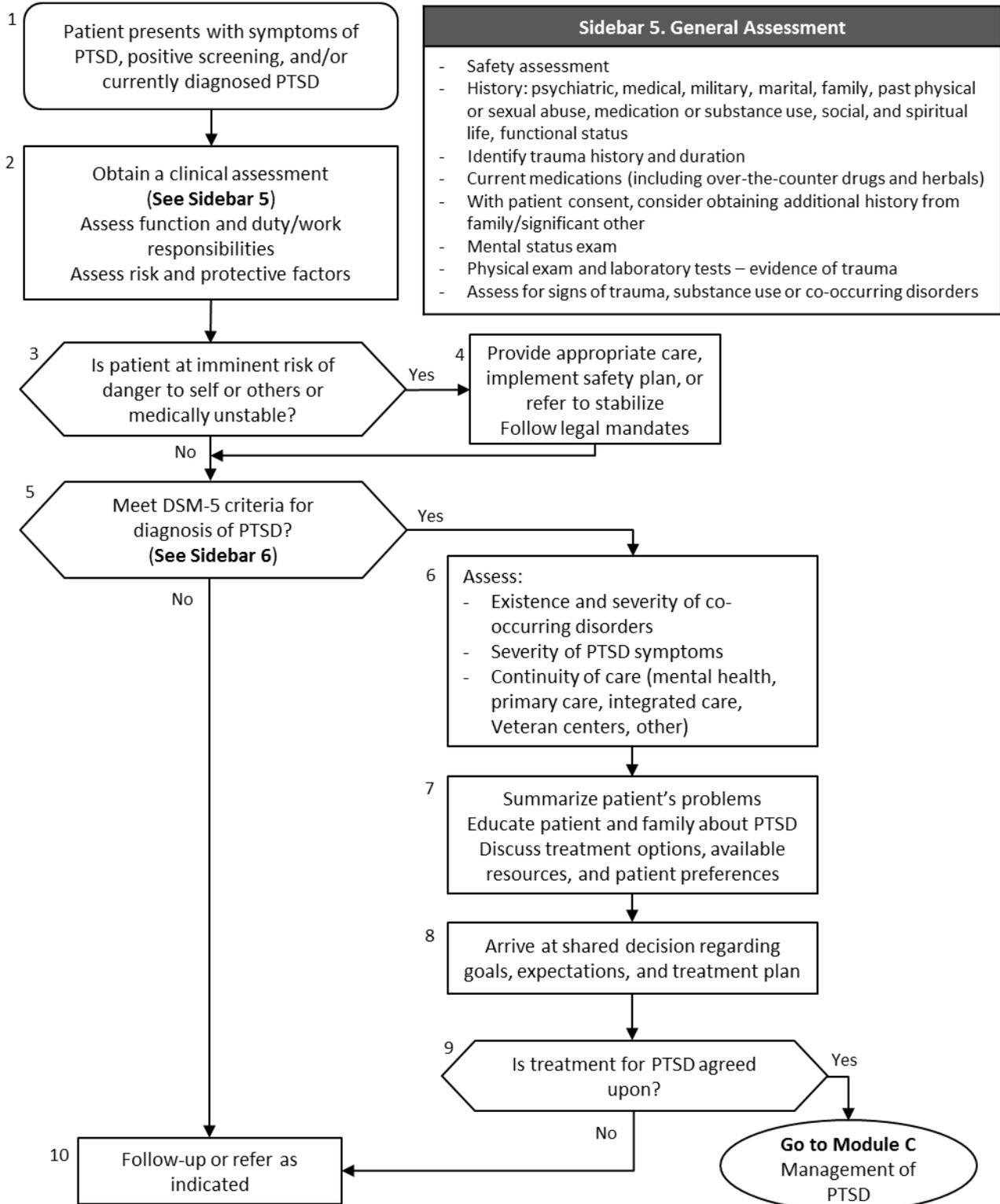
*Strong For recommendation

±Weak For recommendation

Algorithm

Module A: Acute Stress Reaction/Disorder can be found in the full CPG

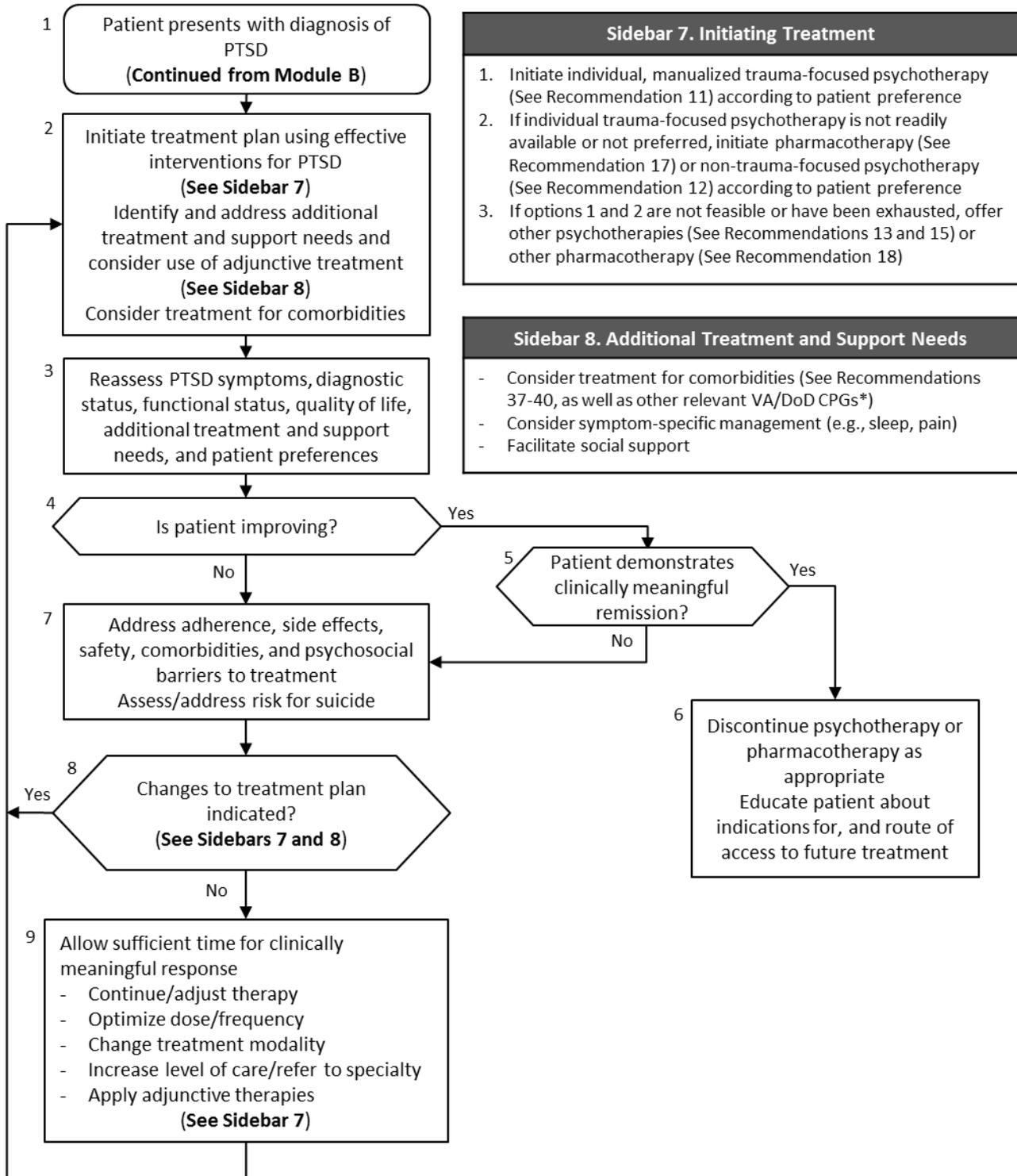
Module B: Assessment and Diagnosis of Posttraumatic Stress Disorder



Abbreviations: DSM: Diagnostic and Statistical Manual of Mental Disorders; PTSD: posttraumatic stress disorder

Sidebar 6. Diagnostic Criteria for Posttraumatic Stress Disorder based on DSM-5	
Criterion A required	The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s): <ol style="list-style-type: none"> 1. Direct exposure 2. Witnessing the trauma 3. Learning that a relative or close friend was exposed to a trauma 4. Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)
Criterion B 1 required	The traumatic event is persistently re-experienced, in the following way(s): <ol style="list-style-type: none"> 1. Intrusive thoughts 2. Nightmares 3. Flashbacks 4. Emotional distress after exposure to traumatic reminders 5. Physical reactivity after exposure to traumatic reminders
Criterion C 1 required	Avoidance of trauma-related stimuli after the trauma, in the following way(s): <ol style="list-style-type: none"> 1. Trauma-related thoughts or feelings 2. Trauma-related reminders
Criterion D 2 required	Negative thoughts or feelings that began or worsened after the trauma, in the following way(s): <ol style="list-style-type: none"> 1. Inability to recall key features of the trauma 2. Overly negative thoughts and assumptions about oneself or the world 3. Exaggerated blame of self or others for causing the trauma 4. Negative affect 5. Decreased interest in activities 6. Feeling isolated 7. Difficulty experiencing positive affect
Criterion E 2 required	Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s): <ol style="list-style-type: none"> 1. Irritability or aggression 2. Risky or destructive behavior 3. Hypervigilance 4. Heightened startle reaction 5. Difficulty concentrating 6. Difficulty sleeping
Criterion F required	Symptoms last for more than one month
Criterion G required	Symptoms cause significant distress or functional impairment
Criterion H required	Symptoms are not due to medication, substance use, or other illness

Module C: Management of Posttraumatic Stress Disorder



*VA/DoD CPGs can be found at the following link: <https://www.healthquality.va.gov/index.asp>. Relevant VA/DoD CPGs to consult may include CPGs for the Management of Major Depressive Disorder, Substance Use Disorder, Bipolar Disorder, Suicide, Chronic Multisymptom Illness, Concussion-mild Traumatic Brain Injury, and others.

Abbreviations: CPG: clinical practice guideline; DoD: Department of Defense; PTSD: posttraumatic stress disorder; VA: Department of Veterans Affairs